I. INDEX

Α

ACCESS II/III, 1-4, 3-5, 3-6, 3-10, 3-12, 3-13, 4-1, 4-2
Adjusted Claims Section of the Remittance and Status
Report, 9-1
Adult Preventive Annual Health Assessments, 4-8
Advance Directives, 3-9
APPENDIX A, 2-12, 2-15, 10-6
APPENDIX C, 2-17
APPENDIX G, 3-4, 3-6, 3-9, 3-12, 4-3, 4-8, 4-10, 411, 4-14, 4-15, 4-16, 5-1, 7-3, 7-4, 7-9, 7-12, 8-1,
8-5, 8-8, 8-9, 10-5
Approved VAN Vendors, 10-4
Automatic Recoupments, 8-10

В

Billing for Personal Injury Cases, 7-5 Billing on the ADA Claim Form, 5-3 Billing on the CMS-1500 Claim Form, 5-2 Billing on the UB-92 Claim Form, 5-3 Billing the Recipient, 3-4 Billing through a Clearinghouse, 10-3 Billing with N.C. Electronic Claims Submission Web-based Tool, 10-2 Billing with Software Obtained from a Vendor, 10-2 Billing with Software Written by your Office or Company, 10-2 Blue and Pink Medicaid Identification Card Information BlueandPinkMedicaidIdentificationCardInforma tion, 2-3 Blue Medicaid Identification Card, 2-5 Buff MEDICARE-AID ID Card, 2-9, 2-10 Buff Medicare-AID ID Card Example, 2-11

C

CA ACCESS (CCNC) Provider Participation, 4-3 CA ACCESS (CCNC) Provider Requirements for Participation, 4-3 CA ACCESS (CCNC) Sanctions, 3-7, 4-5, 4-6 CA ACCESS (CCNC) Terminations, 4-7 CA ACCESS 24 Hour Coverage Requirements, 4-5, 4-8 CA ACCESS Adult Preventive Annual Health Assessments, 4-8 CA ACCESS Exempt Services, 4-13 CA ACCESS Health Check, 4-8 CA ACCESS Hospital Admitting Privileges Requirement, 4-10 CA ACCESS Medical Records Guidelines, 4-11 CA ACCESS Override Requests, 4-14 CA ACCESS Provider Reports, 4-7 CA ACCESS Provider Reports (Emergency Room

Management), 4-7

CA ACCESS Provider Reports (Enrollment Report), 4-3, 4-7, 4-16 CA ACCESS Provider Reports (Quarterly Utilization Report), 4-8 CA ACCESS Provider Reports (Referral Report), 4-8, 4-13 CA ACCESS Provider Requirements, 4-8 CA ACCESS Referral Documentation, 4-13 CA ACCESS Referrals and Authorizations, 4-12, 4-CA ACCESS Referrals for a Second Opinion, 4-13 CA ACCESS Standards of Appointment Availability, CA ACCESS Standards of Wait Times, 4-10 CA ACCESS Transfer of Medical Records, 4-11 CA ACCESS WIC Program Referrals, 4-10 Capitated Payments, 7-1 Centers for Medicare and Medicaid Services, 1-1, 3 Civil Rights Act, 3-2 Claim adjustments, 8-1 Claim Adjustments, 8-1 Claims in Process, 9-2 Claims Payment Summary, 8-12, 9-2 Claims Summary, 9-2 Commonly Asked Questions - CA, 4-16 Commonly Asked Questions – ECS, 10-5 Commonly Asked Questions - Provider Information, Commonly Asked Questions - TPL, 7-6 Completing and Submitting the Medicaid Credit Balance Report, 7-13 Conditions of Participation, Provider, 3-2, 4-6 Copayment Exemptions, 2-19 Copayments, 2-19, 4-16

D

Denied Claims, 2-15, 9-2
Dental Services, Prior Approval, 6-10
Department of Health and Human Services, 1-1, 3
Department of Social Services, 1-1, 3
Determining Third Party Liability, 7-2
Disclosure of Medicaid Information, 3-3
Discounted Fee-for-Service Payments, 7-2
DMA, Clinical Policy and Programs, 1-3, 6-13
DMA, Finance Management, 1-4, 3-4
DMA, Information Services, 1-4, 4
DMA, Program Integrity, 1-5, 3-7, 3-8, 4-6, 4
DMA, Recipient and Provider Services, 1-3
Documentation, 3-3
Durable Medical Equipment, Prior Approval, 6-10

Ε

ECS Important Telephone Numbers, 10-4 Electronic Claims Submission, 5-1 Electronic Data Interchange, 2-12, 10-1, 10-3, 3 Electronic Data Systems, 1-2, 3
Electronic Funds Transfer, 10-4, 10-5, E-1, 3, G-1
Eligibility Categories, 2-1
Eligibility Denials, 2-2, 2-14, 2-15, 2-17
Eligibility Determination, 2-1, 7-11
Eligibility Process, 7-12
Eligibility Reversals, 2-2
Emergency Conditions, 4-9
Enrollment Report, 4-3, 4-7, 4-16
EOB Denials that Do Not Require Filing an
Adjustment, 8-6
EOBs for Eligibility Denials, 2-15, 2-17

Explanation of the Internal Claim Number, 9-6

F

Family Planning Waiver, 1-3, 2-1, 2-6, 2-7 Fee Schedule Requests, 3-4 Financial Payer Code, 9-2

G

General Requests for Prior Approval, 6-6

Н

Health Check Services, 4-8
Health Department Health Check Agreement, 4-8, E-1
Health Insurance Premium Payment (HIPP)
Application, E-1, G-1
Health Insurance Premium Payments, 7-11
HMO Risk Contracting, 4-15
Hospital Admitting Privileges Requirement, 4-10

ı

Informational Adjustment Claims, 9-2
Instructions for Completing the Medicaid Claim
Adjustment Request Form, 8-1
Instructions for Completing the Medicaid Resolution
Inquiry Form, 8-9
Instructions for Completing the Pharmacy
Adjustment Request Form, 8-5
Interactive Recipient Eligibility Verification, 10-3

L

Licensure, 3-1, 3-7 Licensure or Revocation or Suspension, 3-7

M

Managed Care, 1-1, 1-4, 2-3, 2-5, 2-9, 3-5, 3-6, 3-10, 3-13, 4-1, 4-2, 4-3, 4-7, 4-10, 4-13, 4-15, 4-17, 4

Medicaid Claim Adjustment Form, E-1

Medicaid Credit Balance Reporting, 7-12

Medicaid Provider Change Form, 3-6, 3-12, E-1, G-1 Medicaid Resolution Inquiry Form, 7-3, 8-9 Medical Exemption Requests, 4-14 Medical Record Documentation, 3-3 Medicare Crossover Reference Request, G-1

Ν

Noncompliance Denials, 7-2

Ρ

PA, 6-1 Payment for Personal Injury Cases, 7-5 Payment in Full, 3-4 Payment of Health Insurance Premiums, 7-11 Payment Suspension, 3-6 Personal Injury Cases, 7-4, 7-5 Pharmacy Claim Adjustments, 8-5 PI, Determining Areas for Review, 1-5, 3-7, 3-8, 4-6, PI, Informal Hearings, 3-8 PI, Paper Reviews, 3-8 PI, Self-Referral Federal Regulation, 3-8 Piedmont Cardinal Health Plan Card, 2-8 Population Group Payer Code, 9-2 Prior Approval, 4-12, 4-14, 6-1, 6-2, 6-3, 6-6, 6-8, 6-9, 6-10, 6-12, 6-15, 6-17, 6-18, 6-20, 6-20, B-1, E-1, E-2, 3, 4 Provider Agreements, 3-1 Provider Refunds, 7-4, 8-11 Provider Responsibilities, 3-4, 3-8

Q

Quality Management, 1-4

R

Recipient Education, 4-2
Refunds to Medicaid, 7-3
Regional Managed Care Consultants, 4-3
Rehabilitation and Disabilities Acts, 3-2
Requests for Prior Approval of Out-of-State or State-to-State Ambulance Service, 6-8
Resolution Inquiries, 8-8
Resubmission of a Denied Claim, 8-1
Retroactive Eligibility, 2-2

S

Sanction Appeals, 4-7
Service Location, 3-1
Services Provided to Medicare-Eligible Medicaid
Recipients, 7-1
Services Provided to the Mentally Retarded, 6-9
Summary Page, 9-4

T

Termination of Inactive Providers, 3-6
Third Party Insurance, 7-1
Time Limit Override on Third Party Insurance, 7-3
Time Limit Overrides, 8-8
Time Limits for Filing Claims, 5-1
Tip for Filing Adjustments, 8-3
Tips for Completing the Adjustment Form, 8-3
Tort (Personal Injury Liability), 7-4
Transfer of Assets, 2-13
Transfer of Assets Determination, 2-13
Transfer of Assets, Medicaid Recipients Subject to the Policy, 2-13
Transfer of Assets, Services Included in the Policy, 2-13

U

Urgent Conditions, 4-10 Utilization Review for Psychiatric Services, 6-11

V

Value Added Networks, 10-3 Verifying Recipient Eligibility, 3-4 Voluntary Termination, 3-6

W

What Changes Must Be Reported, 3-5 What is the Remittance and Status Report?, 9-1 When Does Eligibility Begin, 2-2 Where to Obtain Information, 7-12